The special advantages of the operation may be enumerated as follows: 1. The safe removal of large hard stones which cannot be removed by any of the other methods. 2. The avoidance of perineal hæmorrhage, of urinary infiltration, of perineal fistula, of laceration of the rectum and neck of the bladder, the prevention of traumatic stricture and cystic hæmorrhage. The avoidance of any interference with the genital apparatus. 3. The prevention of a vesico-vaginal fistula in young women, or of permanent incontinence of urine in aged women. 4. The safest operation in all forms of renal disease, and the only means of saving life in rupture of the bladder. 5. The tendency to recurrence of stone is much less than by lithotrity. Its extreme simplicity, its present reduced rate of mortality, its freedom from danger during its execution and its safety for the general practitioner in comparison with the perineal operations or lithotrity.

He has collected 127 cases operated on since 1879, with a mortality attributable to the operation, of 11, or 9%, which is not high in view of the facts that (1) the causes of death in the majority of cases are due to septic infection and not the immediate effects of the operation itself; the employment of more rigid antisepsis for the bladder should improve this mortality; at the present time there is no ideal antiseptic especially and peculiarly adapted to vesical surgery and he recommends attention to this point. (2) The largest and hardest stones have been reserved for the high operation. The patients have been, as a rule, in poor physical condition. Improvements in the details of bladder antisepsis and extension of the limits of the high operation to include stones of a smaller size, but not to embrace those suitable for litholapaxy, and an earlier period of operation before patients are exhausted from chronic vesical irritation will reduce the rate of mortality so as to compare favorably with any other cutting operation for stone.—*American Surgical Association*, 1887.

VI. Suprapubic Cystotomy for Purposes Other than the Extraction of Calculi. By JOHN H. PACKARD, M.D., (Philadelphia). After a review of the history of hypogastric vesical section, the author cited a number of cases in point, which may be tabulated as follows:

No.	*Age.*	*Date.*	*Cause.*	*Details and Complications.*	*Result.*
1		1883	Hair pin passed per urethram.		Cure.
2	85	July 7, 1885.	Retention due to enlarged prostate.	Drainage through the wound with a glass ovariotomy tube bent like a tracheotomy tube.	Decided improvement, but death two days later from heart failure.
3	43	July 21, 1885.	Retention from old stricture and perineal abscess.	Incision of abscess allowed a catheter to pass into the bladder, but distention recurring; a suprapubic incision allowed a catheter to pass through the neck of the bladder out of the perineal wound. A large mass of slough came from the abdominal wound on the seventh day, which was followed by rapid improvement.	Cure in three months
4	43	July 4.	Retention for four days.	Penis, scrotum and skin of the abdomen swollen and tense. Five incisions.	Cure.
5	63	Aug. 13, 1886.	Retention from enlarged prostate.		Improvement but death from exhaustion on the 16th day.
6	70	April 24, 1887.	Retention from enlarged prostate.	Drainage with rubber tube in wound. Casts and albumen in the urine.	Typhoid condition developed, resulting in death on the 14th day.
7	40	April 24, 1887.	Retention with double inguinal hernia and double hydrocele.	Drainage with rubber tube in the wound.	Urethral obstruction gradually passing away.

As regards the method of procedure, he believed that the fullest antiseptic precautions should be observed in these cases. In most of his cases, the question of distention of the bladder was not considered, as the organ was already in danger of rupture from excess of urine; however, it should never be more than moderately distended by the employment of not over six or eight ounces of a boric acid solution; the solution may be conveniently retained in the bladder by folding the urethra and retaining it so. There is less risk and more advantage in distention of the rectum, for a possible source of danger is obviated by thus preventing the sinking of the bladder into the pelvis until all the arrangements for drainage have been completed. The steadying of the bladder by an assistant when an incision or puncture is to be made, is not only needless but objectionable. The incision through the skin should be free enough to give ready access to the deep parts; in fat persons, about 3 inches and in the thin about 2 inches; no vessel of any importance can be encountered if the incision is made in the median line. Before opening the bladder, it is necessary to secure it in some manner lest it collapse and settle back on puncture, and greatly embarrass the operation; for securing it a small double hook set at a right angle on a stem, or even a small tenaculum may be used to advantage, and in case of a large vesical opening, a double ligature is perhaps the most useful. In cases of retention, the curved trocar and canula may now be used at once, the canula being afterward replaced by a tube; the author makes the opening just large enough for the tube. The proper point for the opening is at the middle of the exposed portion of the vesical wall, which would be about 1 or 1½ inches above the pubes, and thus avoid the peritoneum on one hand and the sinking of the opening below the pubes when the bladder contracts, on the other. Drainage should be provided through a soft rubber tube of a length to be determined for each case, but it should go well into the bladder even when the organ is collapsed and should have lateral openings only near its inner extremity; the external end may be closed by a cork or clip or by bending it; in old men with atonied bladders, he had used glass tubes. He did not favor the prone attitude to facilitate drainage, because of the discomfort it occasioned. If the opening into the bladder has been large, it may be drawn about the tube by two or three catgut sutures. The lips of the external wound should also be brought together by catgut or silkworm gut sutures. He concludes with the following pertinent question: "If the suprapubic operation had been first tried and generally adopted is it likely that the perineal operation would have been afterward performed on account of its greater ease, simplicity and efficiency?"—*American Surgical Association*, 1887.

VII. Operations for Vesical Calculi. By A. VAN DERVEER, M.D., (Albany, N. Y.). This paper presented 41 cases in which the author had operated for stone in the bladder: they represented every kind of stone as to location in the bladder—prostatic, membranous and the spongy portions of the urethra; as regards the formation of soft and hard calculi, the list was singularly complete, while the extremes as to size were remarkable. There were seven cases of perineal lithotomy with two deaths and five recoveries, the former being very old men with very large stones. Of attempted litholapaxy and immediate perineal lithotomy, there were two cases, both of which resulted in death, being severe cases of large stone, the patients presenting a history of much suffering through many years. Of dilatation of the urethra in the female and washing out of fragments or removal of stone entire, there were six cases, all recovering with no complication whatever. Of urethral calculi, there were four cases, all recovering. Of simple lithotrity in the male, there was one case followed by recovery. Of litholapaxies, attempted but not completed, there were four cases, three ending in death and one, in which the stone was hidden in a sac, later undergoing perineal lithotomy and recovering. One was probably complicated with some form of tumor of the bladder with a history of chronic disease of the kidneys; one was a case of chronic alcoholism; one was complicated with sacculated bladder, and the last two were cases of surgical kidney of the gravest kind. Of the litholapaxies in the male, there were eighteen patients and twenty-two operations, four required a second operation; of the number, sixteen recovered and two died; of the latter one died after the first and one after the second operation.

Litholapaxy is indicated in cases were the stone is small or of moderate size, and can be done in very small children, with proper instruments. However, there is much that is wanting in the study of the condition of patients after rapid lithotrity, and valuable statistics on the subject ought soon to have accumulated, but the fallacy of all